

## Symptom Record

Child's Name \_\_\_\_\_ Date: \_\_\_\_\_

Symptoms:

**Circle or write in other symptoms:**

runny nose    sore throat    cough    vomiting    diarrhea    wheezing

trouble breathing    stiff neck    rash    trouble urinating    pain

itching    trouble sleeping    earache    headache    stomachache

Other symptoms:

\_\_\_\_\_

When symptoms began, how long they lasted, how severe, how often?

\_\_\_\_\_

Changes in the child's behavior

\_\_\_\_\_

Child's temperature: \_\_\_\_\_ Time taken: \_\_\_\_\_ (Circle: armpit, oral, or ear canal)

Type and quantity of food and fluid the child ingested in the past 12 hours?

\_\_\_\_\_

Frequency of urine and bowel movement, in the past 12 hours? Any abnormalities?

\_\_\_\_\_

Exposure to medications, animals, insects, soaps, new foods:

\_\_\_\_\_

Exposure to other people ill with similar symptoms? Yes No Unsure

If yes, type of illness or symptoms

\_\_\_\_\_

Child's other medical conditions that might affect this illness (for example: asthma, anemia, diabetes, allergies, and emotional trauma)

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Treatment for given to date and person providing treatment.

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Child should be excluded from child care: YES NO

If yes, when can child return to care:

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Advice from the child's clinician:

Name and title of person completing this form:

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Phone number of person completing this form:

\*Adapted from Model Child Care Health Policies, PA Chapter-American Academy of Pediatrics.  
(2002) 4<sup>th</sup> Ed.